

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: HEALTH CARE FINANCING ADMINISTRATION**

1. TRANSMITTAL NUMBER:

11 - 15

2. STATE:

Michigan

3. PROGRAM IDENTIFICATION:

TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH FINANCING ADMINISTRATION
DEPARTMENT OF HUMAN SERVICES4. PROPOSED EFFECTIVE DATE
October 1, 2011

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.252

7. FEDERAL BUDGET IMPACT:

a. FFY 2012 \$ 0
b. FFY 2013 \$ 08. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Section IV, Pages 17-199. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):
Attachment 4.19-D, Section IV, Pages 17-19

10. SUBJECT OF AMENDMENT:

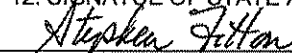
This amendment changes the eligibility criteria for Class I Nursing Facility Rate Relief.

11. GOVERNOR'S REVIEW (Check One):

- ☐
- GOVERNOR'S OFFICE REPORTED NO COMMENT
-
- ☐
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
-
- ☐
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:
Stephen Fitton, Director
Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Stephen Fitton14. TITLE:
Director, Medical Services Administration15. DATE SUBMITTED:
December 22, 2011

16. RETURN TO:

Medical Services Administration
Actuarial Division
Capitol Commons Center - 7th Floor
400 South Pine Street
Lansing, Michigan 48933

Attn: Loni Hackney

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPE NAME:

22. TITLE:

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of MICHIGAN

***Policy and Methods for Establishing Payment Rates
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~~C. Variable Cost Component (continued)~~

~~3. The rate determination methods using base and support costs~~

~~c. The provider's variable rate base is determined as the lesser of the variable rate base or the provider's class wide variable cost limit (VCL), where (continued)~~

~~3) The variable cost limit for private institutions for the mentally ill and mentally retarded is computed by adding the VCL for Class I nursing facilities plus the cost of additional nursing hours per patient care day plus the cost of additional services as required by the Department, as outlined in the Supplement to Attachment 3.1-A.~~

~~4. Nursing Facility Class I Rate Relief~~

~~a. Criteria for Eligibility for NF Class I Rate Relief – A Class I nursing facility provider may apply for rate relief from the usual rate setting process if they meet the following eligibility criteria:~~

~~1) The provider must demonstrate that the current Medicaid reimbursement does not provide them with adequate funding to deliver the level of care to the Medicaid beneficiaries in the facility such that "each resident attains and maintains the highest practicable physical, mental and psycho-social well-being" as required by the Omnibus Budget Reconciliation Act (OBRA) of 1987.~~

~~2) The nursing facility Variable Rate Base amount meets the following criteria:~~

~~a) For a current provider – The facility's Variable Rate Base is at or below the corresponding class Average Variable Cost. The class Average Variable Cost used for this determination is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested; or,~~

~~b) For a new provider in a Medicaid-enrolled nursing facility – The facility's current Variable Rate Base is at or less than 80 percent of the corresponding class Average Variable Cost. The class Average Variable Cost used for this determination is the one that corresponds with the October 1 to September 30 rate year for which rate relief has been requested. (A new facility with a Variable Rate Base between 80 and 100% of the corresponding class Average Variable Cost will be eligible for accelerated rebasing and will be treated as a current provider)~~

~~3) A current Medicaid provider agreement for the facility is in effect, except when applying under criteria 4) e). The rate relief period will be based on the facility, and not the owner, provider, or licensee. A change of ownership, provider, or licensee during the rate relief period would not end the agreement for rate relief under this policy, so long as the new owner, provider, or licensee fully complies with the requirements of the rate relief agreement.~~

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- 4) The provider must also meet at least one of the following five criteria:
- a) The sum of the provider's Variable Rate Base, Economic Inflation Update and other associated rate add-ons (excluding Nurse Aide Training and Testing reimbursement), plus the net Quality Assurance Supplement, must be less than the provider's audited Medicaid variable cost per RESIDENT patient day for the PROVIDER'S TWO FISCAL COST REPORTING PERIODS OF NOT LESS THAN SEVEN MONTHS IMMEDIATELY PRIOR TO THE FIRST PERIOD OF RATE RELIEF. ~~two years prior to the first year of rate relief.~~ Costs for Nurse Aide Training and Testing are not included in the Medicaid variable costs. To demonstrate this difference, the provider must submit an analysis comparing their variable costs incurred and variable costs reimbursed for the two years previous to the year for which rate relief is requested.
 - b) The provider is required, as a result of a survey by the State Survey Agency (SSA), state or federal regulatory agency, to correct one or more substandard quality of care deficiencies to attain or sustain compliance with Medicaid certification requirements. The survey must have occurred within six months prior to the provider's request for rate relief. The provider must submit a copy of the citation and an approved Plan of Correction outlining the action being taken by the provider to address the DEFICIENCIES requirement(s). A COPY OF FACILITY STAFFING LEVELS BEFORE AND AFTER THE SURVEY CITATION MUST BE PROVIDED TO DEMONSTRATE THE STAFFING INCREASE IS SUSTAINED AND IS NOT FOR SHORT TERM TRAINING PURPOSES ONLY; or
 - c) The facility has a significant change in the level of care needed for current Medicaid residents. A significant charge is defined as an increase of at least 10 minutes of nursing care per patient resident per day as demonstrated by Minimum Data Set (MDS) data, which results in a corresponding increase in direct care staffing equal to or greater than the increase in patient minutes per day. The provider must submit an analysis comparing resident acuity levels from the rate base year to current resident acuity levels. The Minimum Data Set (MDS) data must be used for this comparison. This data will be subject to a clinical review by DCH clinical staff. The analysis must also include a comparison of the previous and current nursing staffing levels required based on actual residential census or actual patient days and other nursing related costs or requirements likely to increase the operational costs. This does not include nursing administration staff; or
 - d) The provider is new in a Medicaid Enrolled facility and the facility's most recent cost report submitted to DCH was incomplete, undocumented or had unsubstantiated cost data by the previous provider. Inadequate cost reporting would include non-payment of accrued liabilities due to the previous provider's bankruptcy as determined by Medicaid auditors in accord with Medicaid allowable costs, or inadequate records to support the filed cost report. Proof of the change of ownership must be submitted along with an explanation of why the cost report data is inadequate to calculate the provider's reimbursement rate; or,

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- e) Rate relief is needed because the facility will be closed due to a regulatory action by the State Survey Agency (SSA) state or federal regulatory agency where the facility's closure will result in severe hardship for its residents and their families due to the distance to other nursing facilities, and no new provider will operate the facility at it's current reimbursement rate. A facility would meet this hardship criteria only if a new owner has agreed to take over its operation and if it is either the only nursing facility in the county or, the closing facility has at least sixty-five percent of the Medicaid nursing facility (Class I, III and V) certified beds in that county.

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